Doctor-Patient Discourse: Preparing for Intercultural Medical Communication

医師と患者の談話：異文化医療コミュニケーションの準備

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English

Abstract

This paper continues the author's examination of doctor-patient discourse[1,2] by including the concept of intercultural communicative competence (ICC) and describes the methodology used to introduce it to medical students through a structured dialogue framework and simulated doctor-patient role-playing to develop the necessary communication skills needed for their future careers as medical practitioners. The author also examines data collected from students regarding their opinions about this particular type of skills development.

Key words: Intercultural communication, dialogue, role-play, medical education

1. Introduction

The interpersonal interaction between the doctor and the patient is the basis of providing health care. As such, the importance of a broad range of communication skills, including intercultural communicative competence (ICC), in training future medical practitioners needs strong emphasis. However, medical students in Japan focus primarily on acquiring a vast volume of medical knowledge, with communication skill development receiving virtually no attention.[3)] In addition, the normal environment on a medical school campus in Japan is mono-cultural, that is, Japanese medical students rarely have opportunities to meet non-Japanese during their six-year education program, and initially many students actually believe that in their future as doctors practicing medicine in Japan they will not need to interact with foreigners at all. It is important for them to know that there are actually 2,121,831 foreign residents here (2014)[4)] and almost 20,000,000 foreign tourists and visitors to Japan in 2015 and more expected by 2020[5)], many of whom will require medical services during their stay. Add to this the looming 2020 Tokyo Olympics which will see the arrival of participants from 204 national teams and attract spectators from as many countries, and the opportunities for graduating Japanese doctors to treat non-Japanese patients is rapidly increasing virtually daily. At the Hamamatsu University School of Medicine (HUSM), the author has structured the English conversation classes for first and second year medical students to concentrate primarily on doctor-patient interactions and the development of communicative skills that are transferable to the students' first language. It is the goal of these classes to prepare Japanese medical students for this future as a doctor here by introducing them to the ICC skills they will need to meet this growing challenge. This paper will describe the author's methodology for introducing ICC skills to medical students through a structured dialogue framework and simulated doctor-patient role-playing. First, it is necessary to briefly introduce the concepts underlying ICC.

2. Intercultural communicative competence

Human beings are by their nature social creatures and as they have evolved have developed complex social systems that comprise shared beliefs, developed norms, particular ways of behavior and values that are generally labeled as "culture." This concept of culture also includes how members of a particular social group communicate and interact with others both inside and outside their group. An important element in understanding different cultures is that no one is born with all the attributes of their own particular culture; it is something that must be taught, learnt and practiced. As such, communication between members of different cultures is often complicated by what is not understood on both sides. This means that interactions and communication between two different individuals are made all the more difficult because they do not have enough in common to know how to deal with others from cultures different from their own, leading to errors, miscommunication, misunderstandings, mistrust, fear and in

the worst scenarios, hatred and violence. The solution to this serious problem is to learn how to communicate with others from different cultures and develop what scholars call intercultural communicative competence.

The concept of ICC has been defined very broadly to include a number of critical and interrelated elements, including cultural knowledge, cultural awareness, and interaction skills.[6,7] In brief, it can be summarized as the ability to establish and maintain intercultural relationships, communicate effectively across cultures, and collaborate on areas of mutual interest through one's intercultural knowledge, attitudes, skills, and awareness.[8] In practice, the author believes the way to build ICC skills in students is to guide them in class to develop cultural sensitivity and awareness, expand their multicultural knowledge, and practice a variety of speaking skills to enable them to communicate more effectively with patients of any nationality, such as questioning techniques, explanation techniques, checking comprehension and being able to empathize with the patient. As an example of how the author approaches this in his classes, several years ago he introduced into his English IA classes a multicultural module that aimed to raise first year medical students' awareness of the globalization of medicine and enable them to learn more about the countries that interact with Japan.[9] This module became the basis for learning about ICC in English Conversation I and II.

The field of medicine outside Japan is now giving much more attention to the communicative relationship between the doctor and the patient, focusing in particular with how doctors deal with their countries' migrant populations. This has also been accelerated by the increased movement of people across the world and the globalization of medicine. Consequently, medical professionals need to respond positively to such changes and acquire effective intercultural skills. Intercultural communication strives to prevent the consequences of miscommunication and misunderstandings, which are detrimental to all parties concerned. Indeed, Aoki et al (2008) included in their study of medical miscommunication cases where cultural misunderstandings between doctors and patients in Japan resulted in incorrect diagnosis and inadequate treatment, and "*in cases where there was no medical error, 64.4 percent of the problems were due to miscommunication between medical providers and patients (and families)*."[10]

In the following sections, the process for introducing ICC skills through a structured dialogue framework will be described.

3. Doctor-patient dialogues

Doctor-patient dialogues are more than mere examples of grammar structures and medical terminology; these can also serve as examples of common interactions to develop needed communicative skills that are transferable to the students' first language. Although many medical English textbooks do provide short

examples of doctor-patient dialogues,[11,12,13] they are merely segmentalized snap-shots of a medical consultation and, as is the nature of teaching dialogues, are usually shallow and contrived. For example:

Doctor: How long have you had the cough?
Patient: Oh, for years.
Doctor: Do you smoke?
Patient: I used to smoke heavily, but I gave up a year ago.
Doctor: Do you cough up any phlegm?
Patient: Yes.
Doctor: What colour is it?
Patient: Usually yellow.[11]

To overcome such shortcomings, the author's conversation classes at HUSM require students to undertake some basic research, construct and develop their own practice dialogues of an entire consultation and then allow them to experiment with some of the elements of ICC that would otherwise be ignored.

In class, students are assigned to collaborate in groups of 4 or 6. While working through the syllabus, each member is expected to individually research a system of the human body, supported by in-class work, and diseases afflicting that particular system, and then construct a doctor-patient dialogue based on their findings. To facilitate this process, students are instructed to use and follow a formal framework for doctor-patient dialogues for all their dialogues. The basic structured framework for all classroom doctor-patient dialogues is set as follows:

1. The doctor greets the patient and introduces themselves if it is a first meeting. The doctor should also check the patient's name to establish the basis for following consultations.
2. The presenting complaint; the doctor asks, "What brings you to the clinic today?" to elicit from the patient the nature of their complaint.
3. The doctor asks a minimum of eight symptom questions: the doctor needs to ask good questions about the patient's described symptoms (in a clear and polite manner) to get the information needed to make a good diagnosis. In addition, the doctor needs to show sensitivity to the patient's needs, including ICC elements, and respond to patient discomfort when appropriate.
4. The doctor should ask the patient about their ideas, concerns and expectations, including ICC elements.
5. The doctor should share the examination findings and results with the patient and keep them in the loop to reduce anxiety.
6. The doctor makes a preliminary diagnosis and explains it so the patient can understand.

7. The doctor discusses treatment options, considering the patient's individual situation.
8. The doctor should include a prognosis so the patient can take any appropriate actions.

First year students in English Conversation I follow steps 1 through 6, while second year students in English Conversation II follow steps 1 through 8.

In the following classes, each student shares their information with their group members and group members read over the other members' dialogues to verify the framework and look for missing elements and grammar errors as suggestions for improvement. This enables each student to carefully read up to 5 different dialogues and gain new knowledge about the different body systems and diseases researched by each student that form the basis of their group members' work. Students will then revise their dialogues based on this feedback and on feedback from the teacher. Students are then asked to role-play their dialogues in their groups while the other members listen and provide feedback. Finally, over the next few class sessions, each pair of students will role-play their revised dialogue for the class and receive feedback from the class as well as an assessment by the teacher.

4. Role-play

Role-play offers medical students the opportunity to be active in their learning process by practicing both communication and ICC skills. It also provides opportunities for them to observe their peers in similar activities and to receive feedback from the class and the teacher. Engaging with the ideas embodied in the dialogue framework through role-play situations requires students to make an effort to consider how they as a doctor engages with a patient in that role and provides room for students to re-examine their current belief system derived from their own culture. This in turn enables them to see the importance of ICC elements and allows them to understand how these are part of a successful diagnosis for non-Japanese patients.

5. ICC elements

As described in section 2 of this paper, ICC requires students to develop cultural knowledge, cultural awareness and interaction skills. What are the ICC elements that medical students need to concentrate on and learn how to incorporate into their dialogues? In particular, these are the questions and actions the doctor would take to first learn more about the patient they are about to examine, followed by the interactions to put the patient at ease so as to facilitate the gathering of symptom information needed to make a diagnosis. It can include questions as minor as asking where the patient has come from and why they are visiting Japan, to questions about their actions and behaviors prior to or after falling ill. It may also be necessary to sometimes engage the patient in small talk to put them at ease or reduce their anxiety.

Some questions may be regarded as culturally sensitive, for example, concerning dietary customs, gender and religious issues, or even sexual behaviors, but the doctor will need to learn how to frame such questions so as not to put the patient on the defensive. These are issues that may take a little time and practice to master, but are not beyond the capabilities of the students in class if they are given opportunities to engage with the material by incorporating it into their role-plays. For example, students can be given a card with a patient-identity to role-play; such a card would include several pertinent details that could determine their responses to the doctor's questions. Alternately, if resources are available, simulated patients (SPs) could be utilized in the role-play phase. SPs are people from various age, race, and socioeconomic backgrounds who can role-play the part of patients in mock doctor-patient encounters. SPs are specifically trained to recreate accurately and consistently the history, personality, physical findings, and emotional structure and response pattern of an actual patient at a particular point in time. The use of SPs in classes adds both elements of reality and novelty that can be motivating to many students.[14,15)]

6. Reflection

A very important element of this learning experience is giving students time to reflect about their dialogues, their experience in the role-play and in the class generally. Medical students need to think about the interactions they have participated in or observed and develop a new understanding about the nature of communicating with patients both Japanese and non-Japanese. They are asked to reflect upon what their efforts and exploration revealed about themselves as well as on the feedback from peers and the teacher. Indeed, without this reflection, there is no learning. The next part of this paper will examine a snap-shot of how first year medical students perceive the focus of this methodology in their conversation classes.

7. Survey of students

A survey was initiated in the second semester of 2015. Questionnaires were distributed to 114 first year medical students at HUSM just before the end of the second semester and collected in class; all questionnaires were returned. The questionnaire in Japanese (see Appendix 1a, with English translation in Appendix 1b) contained 10 items that students were asked to rank on a 5-point Likert scale.

8. Results

The following table shows the percentage of respondents for each of the items.

Table 1: Doctor-Patient Communication skills　1st Year Students at HUSM　N = 114

Item	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1 . This learning experience helped me reflect on doctor's communication skills.	48.2%	44.7%	7.0%	0.0%	0.0%
2 . The doctor-patient role-play helped me understand both sides.	36.8	45.6	17.5	0.0	0.0
3 . The dialogue process helped me understand what questions are important to ask patients.	71.9	22.8	3.5	1.8	0.0
4 . Practicing the dialogue process will help me communicate with future patients.	55.3	33.3	10.5	0.9	0.0
5 . Dialogue practice helped my communication and ICC skills.	23.7	43.9	24.6	7.0	0.9
6 . Feedback from group members was useful.	33.3	36.0	25.4	3.5	1.8
7 . I could reflect about how I communicate with others.	21.0	34.2	36.0	7.9	0.9
8 . I think it is important to learn how to talk with both Japanese and non-Japanese patients.	71.1	26.3	2.6	0.0	0.0
9 . I do not think I need to learn how to talk with foreign patients.	1.8	2.6	4.4	20.2	71.1
10. I liked the active dialogue process more than a lecture-style class.	23.7	35.1	36.0	2.6	0.0

9. Discussion

Overall, the first year students responded with a very positive opinion of this approach to learning about medical communication between doctors and patients. Questions 1 and 2 showed students developed a strong awareness of the doctor-patient communication paradigm (92.9% and 82.4%, respectively), with no students in disagreement. Student responses to elements concerning intercultural medical communication, including ICC, varied more widely; questions 5 and 7 reflected the degree to which students were taken out of the communicative comfort zone (67.6% and 55.2%, respectively) and were able to feel positive growth in their communicative skills. In addition, questions 3, 4, 8 and 9 shows their increased awareness of their future communicative interactions as medical professionals with all types of patients (94.7%, 88.6%, 97.4%, and 91.3%, respectively). Finally, questions 6 and 10 reflect the students' learning-style preferences and their ability to work with others collaboratively rather than individually, which also has repercussions on their ability to communicate well with others not only in classes but in their future workplaces.

10. Conclusion

The findings of this paper suggest that first year medical students engaging with ICC concepts as they develop their communication skills become more aware of the multi-faceted nature of doctor-patient communication in Japan. Simulated doctor-patient role-playing creates an active learning environment that magnifies the benefits to the students, as evidenced by their diligence in working through the various process stages of dialogue development and role-play as well as by their responses to the study questionnaire. It is clear that a majority of students surveyed (97.4%) recognized the relevance of ICC to developing the communication skills needed for their future interaction with patients, including non-Japanese, and will now possibly reassess their visions of themselves as medical practitioners in Japan in the future.

References

1. O'Dowd G V G : Doctor-patient communication: An introduction for medical students. *Reports of Liberal Arts Hamamatsu University School of Medicine*, 18 : 39-52, 2004.
2. O'Dowd G V G : Doctor-patient conversations: Dealing with difficult patients. *Reports of Liberal Arts Hamamatsu University School of Medicine*, 26 : 15-24, 2012.
3. Hamilton J : Intercultural competence in medical education: Essential to acquire, difficult to assess. *Medical Teacher*, **31** (9): 862-865, 2009.
4. Statistics Bureau, Ministry of Internal Affairs and Communications: 2-14 Foreign National Residents by Nationality. Retrieved from <http://www.stat.go.jp/english/data/nenkan/1431-02.htm>

5. Otake T : Visitors to Japan surge to record 19.73 million, spend all-time high ¥3.48 trillion. In The Japan Times. 20 January 2016, P. 1.
6. Byram M : *Teaching and Assessing Intercultural Communicative Competence.* Clevedon: Multilingual Matters, 1997.
7. Salo-Lee L : Intercultural Competence in Research and Practice: Challenges of Globalization for Intercultural Leadership and Team Work. In Aalto, Reuter E : Aspects of Intercultural Dialogue. Theory. Research. Applications. Cologne: SAXA, 2006, P.81.
8. Fantini AE : A Central Concern: Developing Intercultural Competence. In Fantini AE ed : *About Our Institution*. SIT Occasional Papers Series: Brattleboro, VT, 2000, P. 25-42.
9. Strong G, Dujmovich J, Mclaughlin R, O'Dowd, G : Seeding change: Intercultural learning in the classroom. In Stewart A, Sonda N eds : *JALT2011 Conference Proceedings*. Tokyo: JALT, 2012, P. 595-606. Retrieved from: < http://jalt-publications.org/proceedings/articles/1785-seeding-change-intercultural-learning-classroom>
10. Aoki N, Uda K, Ohta S, Kiuchi T, Fukui T : Impact of miscommunication in medical dispute cases in Japan. *International Journal for Quality in Health Care*, **20** (5): 358-362, 2008.
11. McCarter S : *Oxford English for Careers: Medicine*. Oxford University Press: Oxford. 2010.
12. Kamiyama S, Opacic R, Imamura K : *English for Medical Students.* Nan'Un-Do: Tokyo. 1994.
13. Nishihara T, Nishihara M, Brown T : *Medical English Clinic*. Cengage Learning: Tokyo. 2010.
14. Kittaka LG : Simulated patients pitch Japan's medical students cultural curve balls. Retrieved from <http://www.japantimes.co.jp/community/2016/01/27/issues/simulated-patients-pitch-japans-medical-students-cultural-curve-balls/#.VqmkGFJkZa4>
15. Kuramoto C, Ashida R, Otaki J : English-speaking SPs in medical education: the motivation factor. 医学教育, **45** (6): 421-423, 2014.

Appendix 1a

浜松医科大学医学部授業評価アンケート

授業名: English Conv I　　January 2016　Group...　A15.. .. ..

＜評価項目・5 段階評価＞　下記の 10 の評価項目に対して、5〜1 の 5 段階評価のマークを濃く丁寧に塗りつぶしてください。

5：大いにそう思う　4：そう思う　3：どちらとも言えない　2：そうは思わない　1：全くそうは思わない

	評価項目	5 段階評価
1	この学習経験は、医師のコミュニケーションスキルに反映し役立っています。	⑤ ④ ③ ② ①
2	医師と患者のロールプレイは両方を理解する助けとなりました。	⑤ ④ ③ ② ①
3	対話のプロセスでは、患者にどのような質問をすることが重要なのか理解することができました。	⑤ ④ ③ ② ①
4	対話のプロセスを実践することは、将来患者とコミュニケーションをとるのに役立ちます。	⑤ ④ ③ ② ①
5	ダイアローグの練習は、私のコミュニケーションと異文化についてスキルに役立ちました。	⑤ ④ ③ ② ①
6	グループメンバーからのフィードバックは有用でした。	⑤ ④ ③ ② ①
7	私は他の人とのコミュニケーションの取り方に反映しています。	⑤ ④ ③ ② ①
8	私は日本人と日本人以外の患者の双方と話をする方法を学ぶことが重要であると考えています。	⑤ ④ ③ ② ①
9	私は外国人患者と話をする方法を学ぶ必要はないと思います。	⑤ ④ ③ ② ①
10	私は講義形式のクラスよりも積極的な対話プロセスが好きでした。	⑤ ④ ③ ② ①

＜自由記述欄＞

Appendix 1b

浜松医科大学医学部授業評価アンケート

授業名：English Conv I　　January 2016　Group...　A15.. .. ..

＜Evaluation scale＞　Please evaluate the 10 items shown below by filling in the number (5-1) that best describes your opinion.

5：Strongly agree　4：Agree　3：I cannot say either way　2：Disagree　1：Strongly disagree

	評価項目	5 段階評価
1	This learning experience helped me reflect on doctor's communication skills.	⑤ ④ ③ ② ①
2	The doctor-patient role-play helped me understand both sides.	⑤ ④ ③ ② ①
3	The dialogue process helped me understand what questions are important to ask patients.	⑤ ④ ③ ② ①
4	Practicing the dialogue process will help me communicate with future patients.	⑤ ④ ③ ② ①
5	Dialogue practice helped my communication and ICC skills.	⑤ ④ ③ ② ①
6	Feedback from group members was useful.	⑤ ④ ③ ② ①
7	I could reflect about how I communicate with others.	⑤ ④ ③ ② ①
8	I think it is important to learn how to talk with both Japanese and non-Japanese patients.	⑤ ④ ③ ② ①
9	I do not think I need to learn how to talk with foreign patients.	⑤ ④ ③ ② ①
10	I liked the active dialogue process more than a lecture-style class.	⑤ ④ ③ ② ①

＜Comments＞